Minutes of the meeting of the Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System held Thursday, May 21, 2015 at the hour of 8:30 A.M. at 1900 W. Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Velasquez called the meeting to order.

Present: Chairman Carmen Velasquez and Directors Emilie N. Junge and Ada Mary Gugenheim (3)

Gerald Bauman (non-Director Member)

Present
Telephonically: Board Chairman M. Hill Hammock (ex-officio)

Absent: None (0)

Additional attendees and/or presenters were:

Cathy Bodnar – Chief Corporate Compliance and Privacy Officer
Douglas Elwell – Deputy Chief Executive Officer, Strategy and Finance
Angela Espinosa – System Director of Health Management Services
Randolph Johnston – Associate General Counsel
Pat Kitchen – McGladrey LLP
Ryan Lipinski – CountyCare Compliance Officer
Elizabeth Reidy – General Counsel
Deborah Santana – Secretary to the Board
Tom Schroeder – Director of Internal Audit

II. Public Speakers

Chairman Velasquez asked the Secretary to call upon the registered public speakers.

The Secretary responded that there were none present.

III. Report from Director of Internal Audit

A. Update on Hektoen Institute of Medicine

Tom Schroeder, Director of Internal Audit, provided a brief update on the Hektoen Institute of Medicine. He stated that Hektoen is the fiscal administrative agent for some grants for the System; there are grants received primarily in two places – within the Stroger Campus and at the Cook County Department of Public Health. Hektoen primarily administers the grants for the Stroger Campus.

Two documents were provided to the Committee in relation to Hektoen. The first is an external audit of Hektoen's financial statements for the period ending August 31, 2014. He stated that this is a clean audit report; there were no issues raised. He noted that, on their balance sheet, under the liabilities section, there is a line that states "Due to Cook County Health and Hospitals System"; as of August 31, 2014, that amount was slightly more than $6 million. What that represents is funds that belong to CCHHS; that is for monies for reimbursement of primarily employee time that was spent performing under the grants. There are policies and procedures around the parameters under which those funds can be used; the funds are primarily used by physicians to further the mission of the System.

III. Report from Director of Internal Audit (continued)

With regard to the other document provided to the Committee, this pertains to the audit of Hektoen's Federal Awards; in the grant portfolio that they manage for CCHHS there are a number of grants that come via federal agencies (example: National Institute of Health). The federal government requires that federal grants be audited by an independent accounting firm; there are a number of requirements that determine the depth and extent to which the grants are reviewed. With respect to this audit, there were no comments, and it was clean with respect to the internal controls around the accounting and financial reporting for the grants. Compliance was deemed to be without exceptions, as well.

Every year, these audits are performed and are brought to this Committee. In prior years, Internal Audit has conducted additional internal audits diving into the issues that were of more specific concern, primarily around those dollars that are due to CCHHS and the use of those funds.

IV. Report from Chief Corporate Compliance and Privacy Officer (Attachment #1)

Cathy Bodnar, Chief Corporate Compliance and Privacy Officer, reviewed the information contained in her report; the report provided an overview of the current Corporate Compliance controls of the CountyCare Health Plan. Ryan Lipinski, CountyCare Compliance Officer, reviewed the information relating to grievances and appeals. The Committee discussed the information.

With regard to the Fraud, Waste and Abuse investigation metrics included on slide 9 of the presentation, Board Chairman Hammock inquired whether cases are carried over from quarter to quarter; he noted that, if they are, there should be an additional metric that reflects the number of cases that were carried over to the next quarter. Ms. Bodnar responded affirmatively; she indicated that the metric for this will be included in future presentations.

Following the review of the information contained in the report, Ms. Bodnar provided updates on some follow-up matters.

Ms. Bodnar stated that Corporate Compliance learned that IlliniCare's Medical Director, Dr. Neal Scharma, was arrested in March; IlliniCare is the System's third party administrator for CountyCare. A criminal complaint was filed against Dr. Scharma alleging the receipt of illegal remunerations; the complaint alleges specifically that he received money from a company in exchange for directing enrollees to that company. It was learned quickly that this activity did not involve CountyCare or any of its members or providers; it allegedly took place completely outside of the County of Cook. However, it was Corporate Compliance's responsibility to assess IlliniCare's process in responding to and evaluating the situation. On the day of his arrest, Dr. Scharma was placed on administrative leave. All access to any of IlliniCare's systems, including any of the CountyCare systems, was disabled and he was denied entry into the premises. An independent law firm was immediately engaged to investigate the allegations; on April 20th Dr. Scharma was terminated from IlliniCare for gross misconduct. Corporate Compliance reviewed the onboarding process at IlliniCare; their process included securing financial disclosures, credit checks, employment references, criminal background checks and licensure verifications, in addition to the routine interviews that are conducted for onboarding. She also understands that there are processes in place to monitor the Medical Director's time. Right now, based on the information gathered, Corporate Compliance feels confident that IlliniCare has the appropriate processes in place; she noted that there are some areas that they could strengthen that they have addressed with IlliniCare, but this did not affect CountyCare. It did affect IlliniCare, and IlliniCare does have processes in place to address something like this happening. This does not appear to be an issue with IlliniCare as a whole, it appears to be an issue of an individual working alone.

IV. Report from Chief Corporate Compliance and Privacy Officer (continued)

On a separate matter, Ms. Bodnar stated that, at the Quality and Patient Safety Committee Meeting last month, Dr. John O'Brien, Director of Professional Education, talked about resident activity and cap sharing agreements. There were some questions that arose after that meeting, so Corporate Compliance reviewed the matter. It was determined that Stroger Hospital may enter into resident cap sharing arrangements and redistribute its residents to affiliated hospitals. That is absolutely appropriate. Rules and regulations are silent as to whether or not a hospital can receive payment from another hospital, or within a group, when it is transferring those unused resident slots; that silence is not interpreted as prohibitive.

V. Action Items

A. Proposed revisions to CCHHS Conflict of Interest Policy (Attachment #2)

Ms. Bodnar presented the proposed revisions to the CCHHS Conflict of Interest Policy.

> Director Gugenheim, seconded by Director Junge, moved to approve the proposed revisions to the CCHHS Conflict of Interest Policy. THE MOTION CARRIED UNANIMOUSLY.

B. Minutes of the Audit and Compliance Committee Meeting, March 19, 2015

> Director Gugenheim, seconded by Director Junge, moved to accept the minutes of the Audit and Compliance Committee Meeting of March 19, 2015. THE MOTION CARRIED UNANIMOUSLY.

C. Any items listed under Sections V and VI

VI. Closed Meeting Items

A. Discussion of preliminary draft FY2014 CCHHS Audited Financial Statements with external auditors
B. Report from Director of Internal Audit
C. Report from Chief Corporate Compliance and Privacy Officer
D. Discussion of Personnel Matters

> Director Gugenheim, seconded by Director Junge, moved to recess the open meeting and convene into a closed meeting, pursuant to the following exceptions to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(**1**), regarding "the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity," and 5 ILCS 120/2(c)(**29**), regarding "meetings between internal or external auditors and governmental audit committees, finance committees, and their equivalents, when the discussion involves internal control weaknesses, identification of potential fraud risk areas, known or suspected frauds, and fraud interviews conducted in accordance with generally accepted auditing standards of the United States of America." THE MOTION CARRIED UNANIMOUSLY.

VI. Closed Meeting Items (continued)

Chairman Velasquez declared that the closed meeting was adjourned. The Committee reconvened into the open meeting.

VII. Adjourn

As the agenda was exhausted, Chairman Velasquez declared that the meeting was ADJOURNED.

Respectfully submitted,
Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXX
Carmen Velasquez, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

ATTACHMENT #1

AUDIT & COMPLIANCE COMMITTEE OF THE CCHHS BOARD OF DIRECTORS

Corporate Compliance Report
May 21, 2015

COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Meeting Objectives

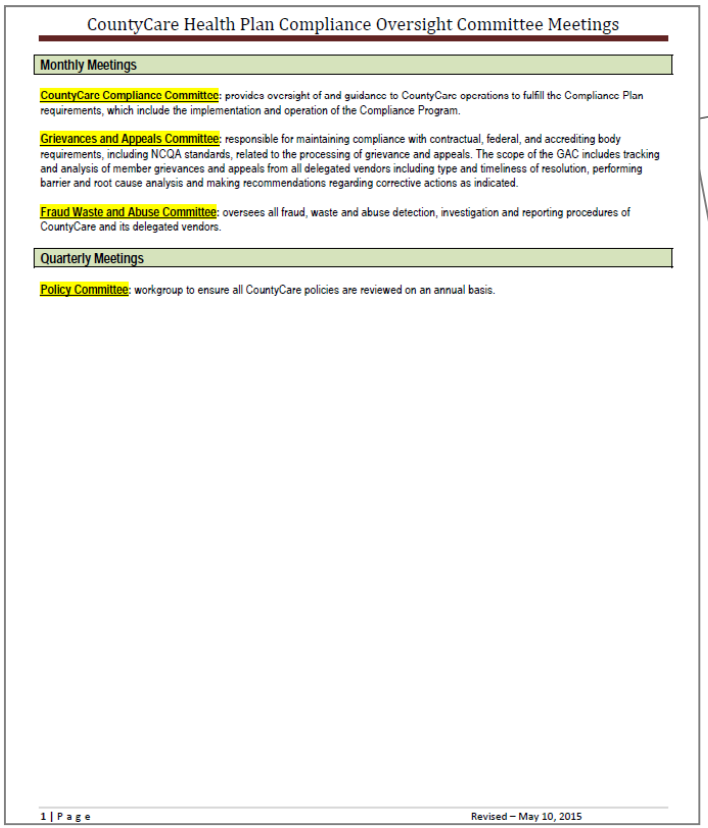
Examine Current Corporate Compliance Controls of the CountyCare Health Plan through,

- CountyCare Oversight Meetings
- Grievances and Appeals Monitoring
- Fraud, Waste, and Abuse Activity

Follow Up on Matters Raised by the Board

CountyCare Oversight Structure

Eighteen (18) Committees have been established to ensure proper oversight and monitoring of CountyCare's operations, policies and compliance with contractual terms.



CountyCare Health Plan Compliance Oversight Committee Meetings

Monthly Meetings

CountyCare Compliance Committee: provides oversight of and guidance to CountyCare operations to fulfill the Compliance Plan requirements, which include the implementation and operation of the Compliance Program.

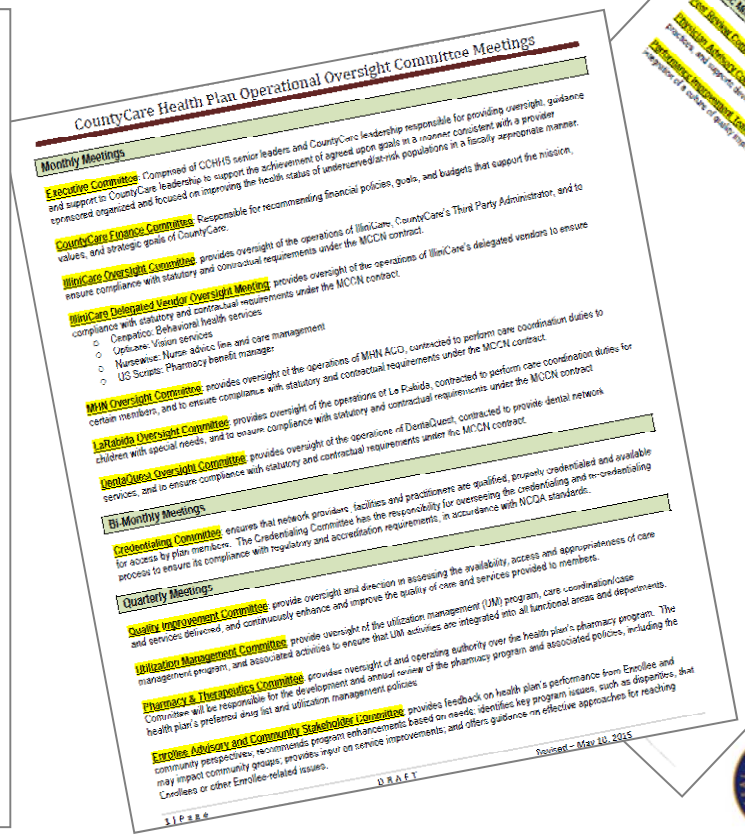
Grievances and Appeals Committee: responsible for maintaining compliance with contractual, federal, and accrediting body requirements, including NCQA standards, related to the processing of grievance and appeals. The scope of the GAC includes tracking and analysis of member grievances and appeals from all delegated vendors including type and timeliness of resolution, performing barrier and root cause analysis and making recommendations regarding corrective actions as indicated.

Fraud Waste and Abuse Committee: oversees all fraud, waste and abuse detection, investigation and reporting procedures of CountyCare and its delegated vendors.

Quarterly Meetings

Policy Committee: workgroup to ensure all CountyCare policies are reviewed on an annual basis.

1 | P a g e Revised – May 10, 2015



CountyCare Health Plan Operational Oversight Committee Meetings

Monthly Meetings

Executive Committee: Composed of CCHHS senior leaders and CountyCare leadership responsible for providing oversight, guidance and support to CountyCare leadership to support the achievement of agreed upon goals in a manner consistent with a provider sponsored organized and focused on improving the health status of underserved/at-risk populations in a fiscally appropriate manner.

CountyCare Finance Committee: Responsible for recommending financial policies, goals, and budgets that support the mission, values, and strategic goals of CountyCare.

IlliniCare Oversight Committee: provides oversight of the operations of IlliniCare, CountyCare's Third Party Administrator, and to ensure compliance with statutory and contractual requirements under the MCCN contract.

IlliniCare Delegated Vendor Oversight Meeting: provides oversight of the operations of IlliniCare's delegated vendors to ensure compliance with statutory and contractual requirements under the MCCN contract.

- Carepatron: Behavioral health services
- Optisure: Vision services
- Nursewise: Nurse advice line and care management
- US Scripts: Pharmacy benefit manager

MHN Oversight Committee: provides oversight of the operations of MHN AGO, contracted to perform care coordination duties for certain members, and to ensure compliance with statutory and contractual requirements under the MCCN contract

LaRabida Oversight Committee: provides oversight of the operations of La Rabida, contracted to perform care coordination duties for children with special needs, and to ensure compliance with statutory and contractual requirements under the MCCN contract

DentaQuest Oversight Committee: provides oversight of the operations of DentaQuest, contracted to provide dental network services, and to ensure compliance with statutory and contractual requirements under the MCCN contract.

Bi-Monthly Meetings

Credentialing Committee: ensures that network providers, facilities and practitioners are qualified, properly credentialed and available for access by plan members. The Credentialing Committee has the responsibility for overseeing the credentialing and re-credentialing process to ensure its compliance with regulatory and accreditation requirements, in accordance with NCQA standards.

Quarterly Meetings

Quality Improvement Committee: provide oversight and direction in assessing the availability, access and appropriateness of care and services delivered, and continuously enhance and improve the quality of care and services provided to members.

Utilization Management Committee: provide oversight of the utilization management (UM) program, care coordination/case management program, and associated activities to ensure that UM activities are integrated into all functional areas and departments.

Pharmacy & Therapeutics Committee: provides oversight of and operating authority over the health plan's pharmacy program. The Committee will be responsible for the development and annual review of the pharmacy program and associated policies, including the health plan's preferred drug list and utilization management policies

Enrollee Advisory and Community Stakeholder Committee: provides feedback on health plan's performance from Enrollee and community perspectives; recommends program enhancements based on needs; identifies key program issues, such as disparities, that may impact community groups; provides input on service improvements; and offers guidance on effective approaches for reaching Enrollees or other Enrollee-related issues.

DRAFT Revised – May 10, 2015

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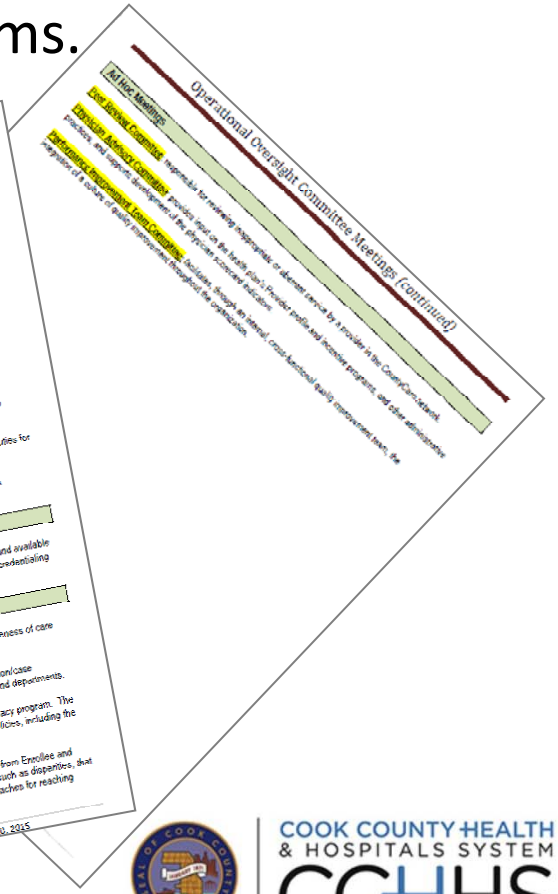

Operational Oversight Committee Meetings (continued)

Ad Hoc Meetings

Best Beyond Committee: responsible for reviewing nonprogram, or alternate service by a provider in the CountyCare network, practices, and opportunities for development of the physician accredited education.

Physician Advisory Committee: provides input on the health plan's Provider profile and incentive programs, and other administrative navigation of a complex or quality improvement throughout the organization.

Performance Improvement Team Committee: facilitate, through an internal, cross-functional quality improvement team, the

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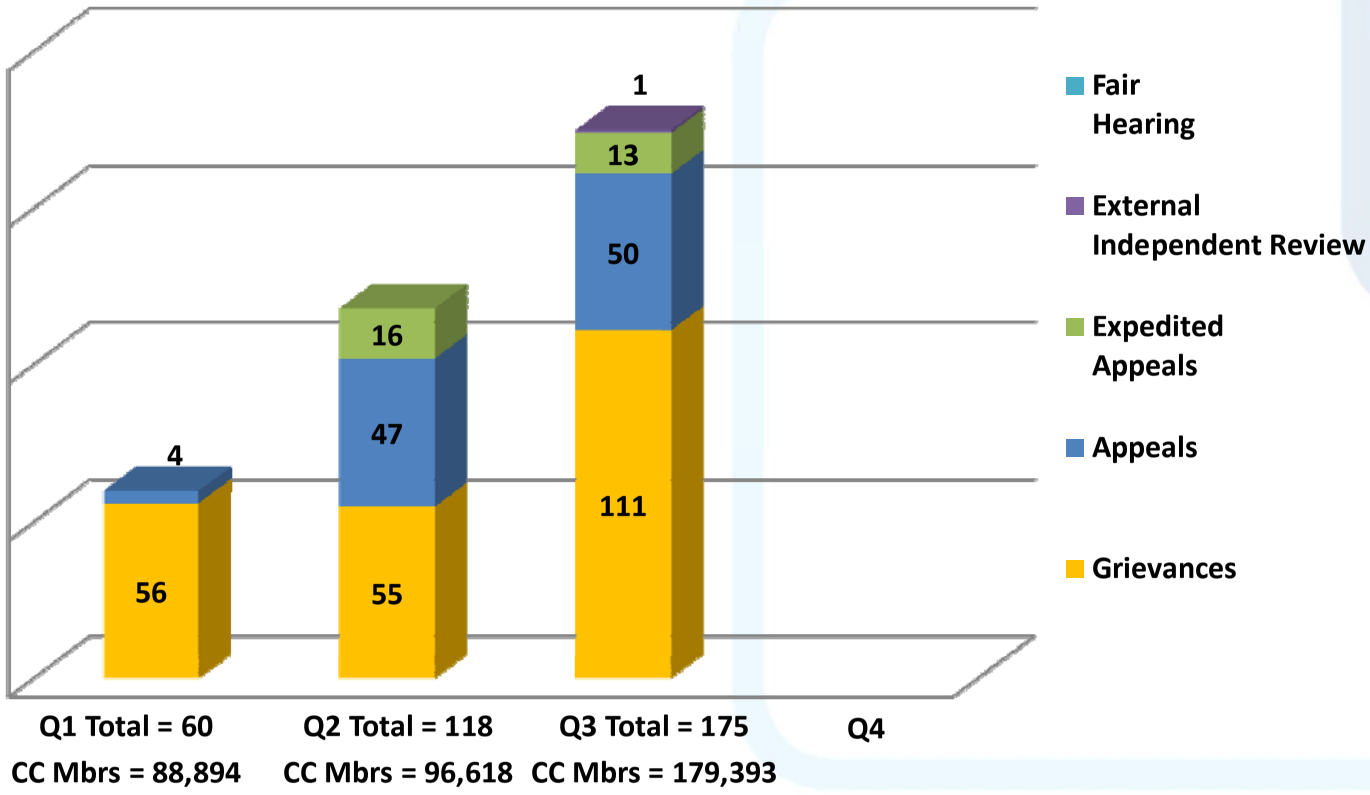
Grievances & Appeals Process

- Provides a mechanism for Members to file complaints or Providers to file appeals when a request for a medical item or service is denied by CountyCare.
- Allows for tracking of grievances and appeals by category, volume and resolution.
- Contributes to identify program improvement opportunities, which may reduce the issues that prompt grievances and appeals.
- Represents a primary mechanism for CCHHS Corporate Compliance and CountyCare operations to exercise oversight of the third party administrator (TPA) and other vendor operations.

Grievances & Appeals Metrics

State Fiscal Year

July 2014 – June 2015



Fraud, Waste and Abuse Program

The Goal: To protect the member in the delivery of healthcare services through timely detection, investigation and prosecution.

Achieved by establishing:

- Training programs for CountyCare employees, vendors, and subcontractors.
- Defining methods to identify, prevent, review and initiate corrective actions against any Provider/Member suspected of participating in Fraud, Waste, and/or Abuse (FWA) activities.
- Developing policies and procedures, including outlining the workflow to be followed in the event that a potential issue or overpayment is identified.
- Reporting identified issues, including referrals to state and local authorities.

FWA Training

- Initial onboarding for staff and providers.
- CountyCare workforce training includes:
  - Focused HFS OIG FWA in-person training;
    attendees: CountyCare staff, third party administrator (IlliniCare) compliance staff, CCHHS staff with oversight, Cook County Office of Inspector General (OIIG)
  - Local and National Conferences;
  - CCHHS annual education to incorporate FWA training.

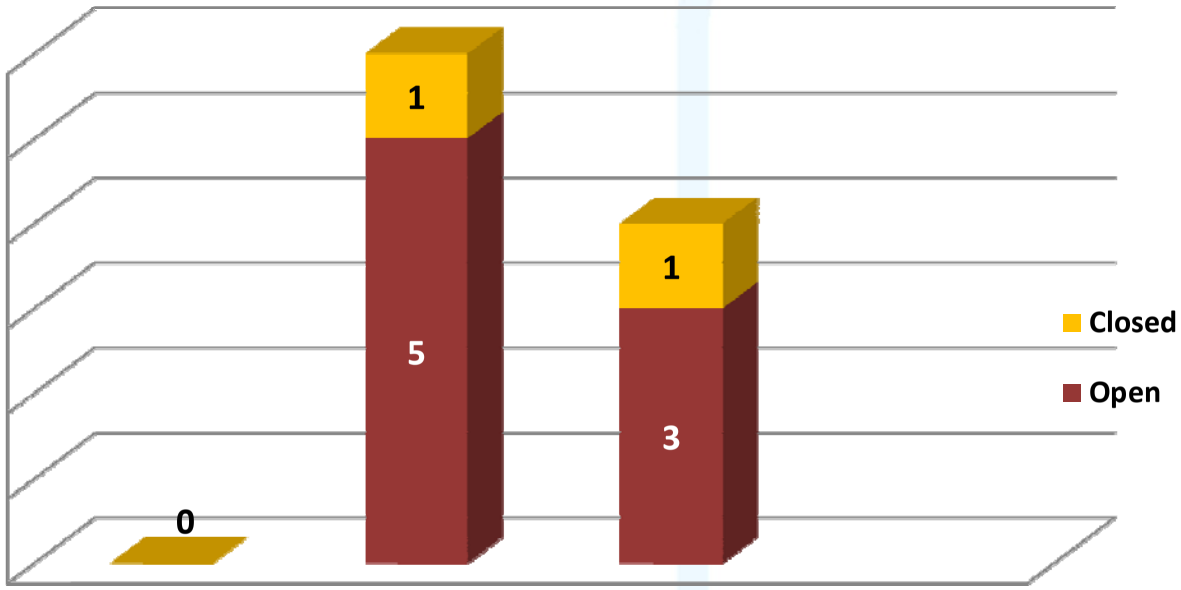
FWA Methods

- Define a cohesive process across all delegated vendors with centralized reporting to Corporate Compliance and hold vendors accountable.
- Monitor Payment Integrity and Special Investigations Unit Activities.
- Develop an annual work plan focusing on vulnerable areas/services.
  For example, the 2015 work plan includes,
  - Adult Day Services;
  - Transportation;
  - High Cost Drugs;
  - Hospice;
  - Home & Community Based Waiver Programs;
  - Flexibility to respond to emerging issues.

FWA Investigation Metrics

State Fiscal Year

July 2014 – June 2015



Q1 Total = 0	Q2 Total = 5	Q3 Total = 3	Q4
Providers* = 285	Providers* = 318	Providers* = 325	
Mbr = 88,894	Mbr = 96,618	Mbr = 179,393	

* The Provider count is based upon the Taxpayer Identification Number (TIN). There is a many to one ratio.

FWA Member Restriction Programs

Pharmacy "Lock-In Program"

- Designed to detect and prevent abuse of the pharmacy benefit by restricting Members to one specific pharmacy for 1 year.
- Referrals come from two sources:
  - Members who were previously restricted in Medicaid's Fee-for-Service Program
  - CountyCare's criteria

<u>CountyCare Pharmacy Lock-In Program Participants</u>

State Fiscal Year 2015 Metrics

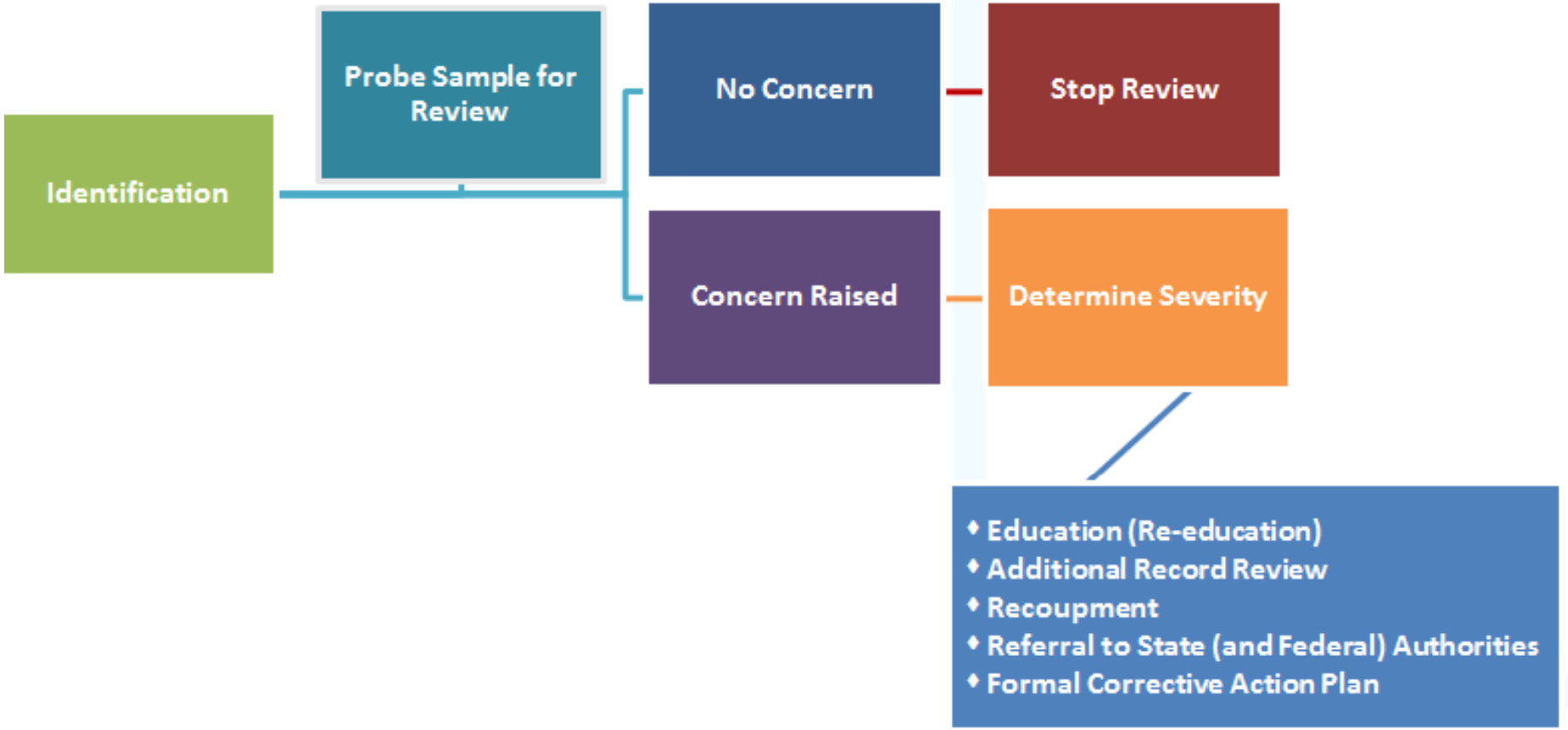
Q1 – 1 member

Q2 – 0 (no members)

Q3 – 3 members

FWA Policies & Procedures

Process flow for claims review. Goal is uniformity with each delegated vendor. FWA processes assure consistency.



HFS OIG Program Oversight Meetings

Monthly meetings are coordinated through Corporate Compliance and involves CountyCare as a whole.

- Agenda topics include review of:
  - Monthly FWA Log;
  - Work Plan and Payment Integrity Activities;
  - Recipient Restriction/Lock In Program Activity;
  - Adverse actions and involuntary terminations;
  - OIG sanctions, payment suspensions, sanctions and integrity agreements; and
  - Current topics, trends, fraud schemes, and program vulnerabilities.

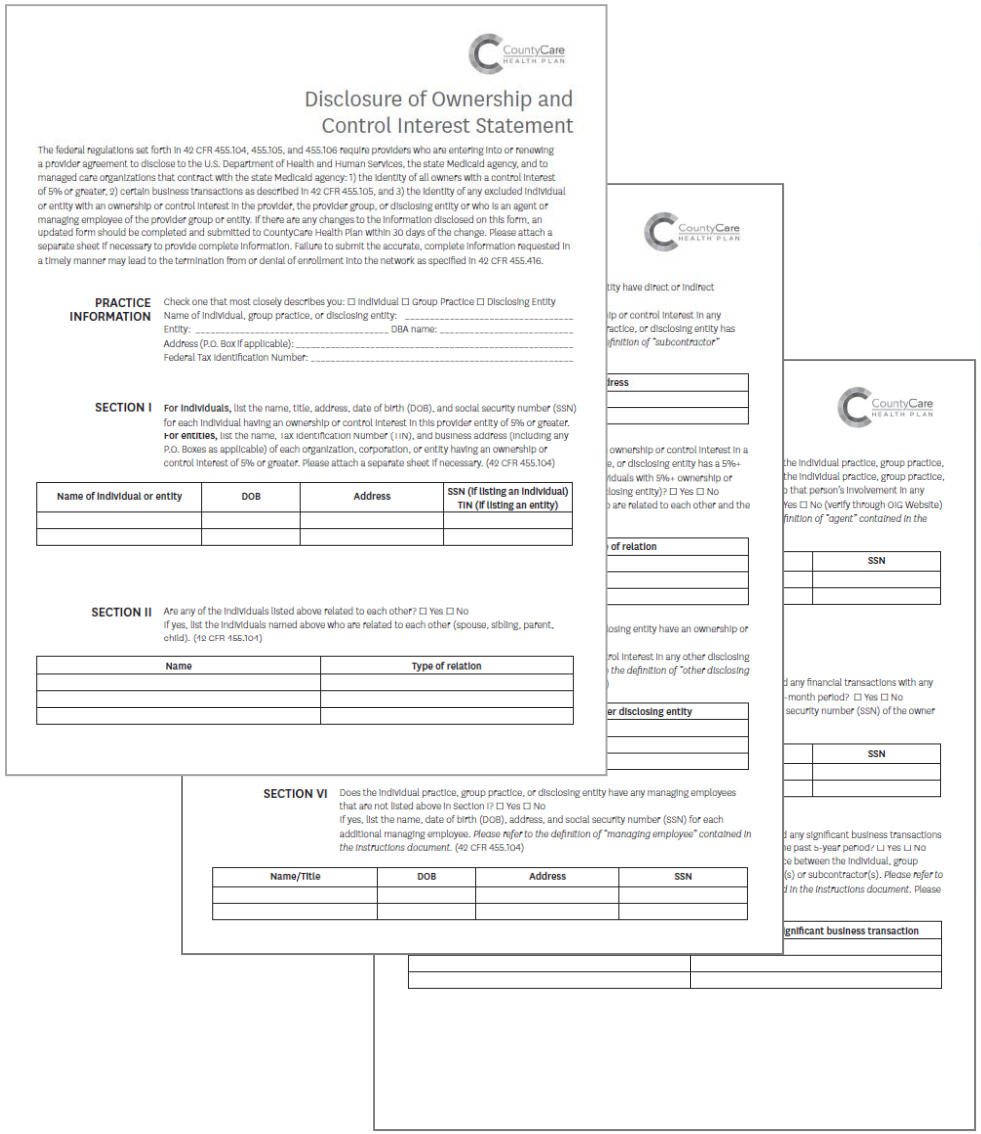
Conflict of Interest Policy Update

Updates:

- Strengthens to incorporate the latest industry standards;
- Integrates CountyCare and incorporate specific contractual requirements;
- Broadens to include additional required reporters; and
- Modifies the frequency requirement for certain medical staff members.

Action: Review and Approve

FWA Disclosure of Ownership Requirement



CountyCare HEALTH PLAN

Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105, and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105, and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to CountyCare Health Plan within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination from or denial of enrollment into the network as specified in 42 CFR 455.416.

PRACTICE INFORMATION Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of individual, group practice, or disclosing entity: _____
Entity: _____ DBA name: _____
Address (P.O. Box if applicable): _____
Federal Tax Identification Number: _____

SECTION I **For individuals,** list the name, title, address, date of birth (DOB), and social security number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater. **For entities,** list the name, Tax Identification Number (TIN), and business address (including any P.O. Boxes as applicable) of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary. (42 CFR 455.104)

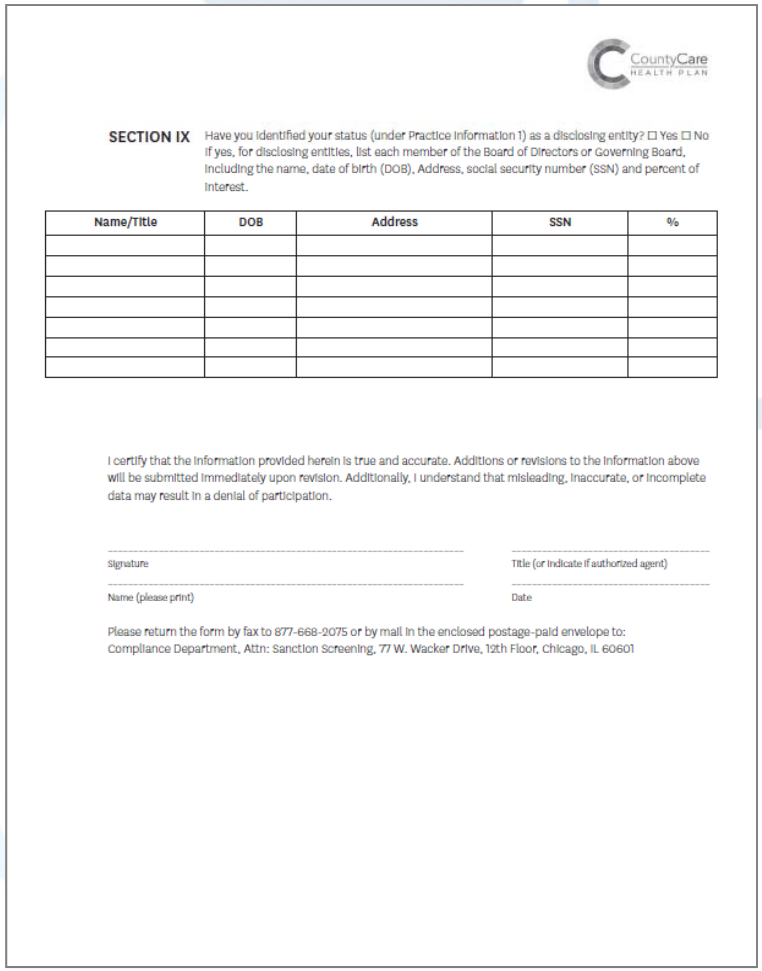
Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

SECTION II Are any of the individuals listed above related to each other? ☐ Yes ☐ No
If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Name	Type of relation

SECTION VI Does the individual practice, group practice, or disclosing entity have any managing employees that are not listed above in Section I? ☐ Yes ☐ No
If yes, list the name, date of birth (DOB), address, and social security number (SSN) for each additional managing employee. *Please refer to the definition of "managing employee" contained in the Instructions document.* (42 CFR 455.104)

Name/Title	DOB	Address	SSN



CountyCare HEALTH PLAN

SECTION IX Have you identified your status (under Practice Information 1) as a disclosing entity? ☐ Yes ☐ No
If yes, for disclosing entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, social security number (SSN) and percent of interest.

Name/Title	DOB	Address	SSN	%

I certify that the information provided herein is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ Title (or indicate if authorized agent) _____

Name (please print) _____ Date _____

Please return the form by fax to 877-668-2075 or by mail in the enclosed postage-paid envelope to: Compliance Department, Attn: Sanction Screening, 77 W. Wacker Drive, 12th Floor, Chicago, IL 60601

Follow Up

Closed Session

ATTACHMENT #2

PURPOSE

The purpose of this policy is to help ensure that the business and professional activities of the Cook County Health & Hospitals System (CCHHS) are conducted free of actual conflicts of interest, or the appearance of any conflicts of interest, and to protect the interests of CCHHS when it is contemplating entering into a transaction or arrangement.

AFFECTED AREAS

This Policy affects Covered Persons within all CCHHS affiliated operating units including John H. Stroger, Jr. Hospital of Cook County, Provident Hospital of Cook County, Oak Forest Health Center, Ruth M. Rothstein CORE Center, Ambulatory & Community Health Network, Cermak Health Services of Cook County, ~~and~~ Cook County Department of Public Health, and CountyCare.

DEFINITIONS

A. Conflict of Interest: A Conflict of Interest may exist when:
   a. a Covered Person, or his/her Personal Relationships, is doing business with CCHHS or any of its operating units;
   b. a Covered Person, or his/her Personal Relationships, has an interest in any issue, item, matter or transaction that involves CCHHS or its operating units or that is under consideration by CCHHS or its operating units;
   c. a Covered Person, or his/her Personal Relationships, is in a position to influence business or other decisions including patient access or care of CCHHS in ways that could lead or appear to lead to the personal gain or advantage of such person, his/her Personal Relationships, or outside entities.

B. Covered Person: All officers, directors, Board committee members, advisory councils, employees, members of the CCHHS medical staff or house staff, researchers, students and contractor personnel carrying out the business or professional activities of ~~the~~ CCHHS.

C. Doing Business: Having or negotiating the creation of a contract or agreement, whether verbally or in writing, that involves the commitment of (either in a single transaction or a combination of transactions) $2,500 or more of CCHHS funds or funds controlled by CCHHS.

D. Gift: Any gratuity, discount, entertainment, hospitality, loan, forbearance, or other tangible or intangible item having monetary value including, but not limited to, cash, food and drink, and honoraria for speaking engagements related to or attributable to a person's status as a Covered Person.

E. Interest: Any professional, personal, financial, legal or equitable economic interest (whether or not subject to an encumbrance or a condition), activity, arrangement, or relationship, which is beneficial in nature and is owned or held, either directly or indirectly, by a Covered Person (or through a Personal Relationship or Person of Influence) with any entity with which CCHHS has or may in the future be doing business. The term "Interest" includes, but is not limited to the following examples,

a. An ownership interest; serving as a member, officer, director, committee member, partner, paid consultant, or employee of the same or a related business, or having a financial interest in the same or a related business;
b. Participation in any outside activity that could interfere significantly with the Covered Person's work time obligation;
c. Receipt of fees, or other compensation or remuneration from an entity as a result of professional services, consulting, speaking engagements, royalties, patents, copyrights, or other intellectual property rights.

F. Personal Relationships: Covered Person's spouse, children, parents, siblings, grandchildren, and their spouses; the Covered Person's spouse's parents, siblings, children, grandchildren, and their spouses; and any Person of Influence.

G. Person of Influence: A person with a close personal or business connection with a Covered Person who would likely influence the decisions of the Covered Person.

POLICY

Covered Persons shall not be involved in any situation or circumstance that would cause the Covered Person to have a Conflict of Interest. This prohibition includes the Personal Relationships of the Covered Person.

No Covered Person shall accept any gift from any entity, or an employee, contractor or agent of an entity, with which CCHHS or its operating units is doing business or with which CCHHS has done business within the past three years.

Covered Persons are responsible for addressing Conflicts of Interest, whether actual or those that have the appearance of a Conflict of Interest. Covered Persons must comply with the provisions of this Policy.

Covered Persons have a duty to disclose the existence of a possible Conflict of Interest and all material facts relating to the possible Conflict of Interest, as provided in the policy.

No Covered Person who has or may have a Conflict of Interest with respect to a transaction or decision shall participate in the transaction or decision, unless authorized to participate by CCHHS Corporate Compliance.

The CCHHS Conflicts of Interest Policy covers the following areas:

1. Conflicts of Interest in Day-to-Day Business Operations of CCHHS Affiliates
~~1.~~2. Conflicts of Interest in Day-to-Day Business Operations of CountyCare
~~2.~~3. Conflicts of Interest in Patient Care
~~3.~~4. Conflicts of Interest in Research Activities
~~4.~~5. Conflicts of Interest in Educational Activities

All Covered Persons shall preserve and protect the interests and assets of CCHHS. The business and professional activities of CCHHS must be conducted in the best interests of CCHHS, without favoritism or preference based on personal considerations. Accordingly, each Covered Person must avoid situations, which may give rise to a Conflict of Interest or the appearance of a Conflict of Interest.

CCHHS has adopted a ~~Standard of Conduct (Code of Ethical Conduct)~~Code of Ethics that supplements the Cook County Ethics Ordinance. This defines CCHHS' standards for ethical behavior by CCHHS Personnel in

carrying out CCHHS operations. Among other things, the Code of ~~Ethical Conduct~~Ethics is designed to protect the integrity of clinical decision-making. Patient care decisions must be based on the healthcare needs of the patient, independent of compensation, financial arrangement or favor that may benefit the healthcare provider or CCHHS.

Research activities at CCHHS must be carried out with the utmost integrity. All research activities must be approved in advance by the Institutional Review Board of the Cook County Health and Hospitals System and by CCHHS management.

Educational activities (including professional and public education) at CCHHS must be free from bias and carried out in a manner that serves the educational component of CCHHS' Mission and responsibilities as a public health system, and not the personal interests of any Covered Person.

~~Duty to Disclose: Covered Persons have a duty to disclose the existence of a possible Conflict of Interest and all material facts relating to the possible Conflict of Interest, as provided in this Policy. No Covered Person who has or may have a Conflict of Interest with respect to a transaction or decision shall participate in the transaction or decision unless authorized to participate by Corporate Compliance~~.

PROCEDURE

A. The Conflict of Interest process for CCHHS, including Disclosure Statements and conflict resolution, shall be coordinated by the CCHHS Corporate Compliance, in consultation with the Office of General Counsel. Questions regarding the Conflict of Interest Policy should be directed to the Corporate Compliance Office.

B. Duty to Disclose: All Covered Persons have a duty to disclose the existence of a possible Conflict of Interest and all material facts relating to the possible Conflict of Interest.
   1. CountyCare Requirements: Covered Persons specifically involved in CountyCare operations have a duty to disclose any possible Conflict of Interest to Corporate Compliance within twenty-four (24) hours of discovering such possible Conflict of Interest, so that CCHHS may adequately meet the conflict of interest requirements of the County Managed Care Community Network (MCCN) contract with HFS.
   2. No Covered Person who has or may have a Conflict of Interest with respect to a transaction or decision shall participate in the transaction or decision unless authorized to participate by Corporate Compliance

C. Required Reporters: The following Covered Persons are required to complete disclosure forms on an annual basis:
   1. Board of Directors members and committee members appointed by the Board;
   2. Management and individuals in leadership positions;
   3. Supply Chain Management personnel, members of committees charged with selection of products or services to be purchased and/or anyone in a position to influence purchasing decisions (e.g. case management, social workers);
   4. Any Covered Persons who are specifically involved in CountyCare operations;
   5. Any ~~CCHHS personnel~~Covered Persons who works more than or equal to twenty (20) hours per week or forty (40) hours per pay period and have commitments or relationships with ~~competing~~ other organizations;
      a. Medical staff members that work less than twenty (20) hours per week or forty (40) hours per pay period must submit an Accounting of Disclosures survey during the credentialing/re-credentialing process.

~~4.~~6. Any CCHHS personnel who have outside employment relationships with businesses that seek to do business with CCHHS

~~5.~~7. Any CCHHS personnel who previously had a conflict identified.

C. Disclosure Statement (Conflict of Interest Disclosure Statement): Annually, a Covered Person who is a Required Reporter must accurately complete a Disclosure Statement and affirm that they: (i) have received a copy of this Conflict of Interest Policy; (ii) have read and understand this Policy; and (iii) agree to comply with this Policy. Covered Persons will submit the Disclosure of Interests Statement on a timely basis to the CCHHS Corporate Compliance Office.

D. Duty to Update Disclosure Statement: It will be the continuing duty of each Covered Person who is sent such a Disclosure Statement to advise the Chief Compliance Officer within 10 business days of the occurrence of any event that would have been described in the Conflict of Interest (COI) Disclosure Statement had it occurred or been known at the time the COI Disclosure Statement was originally completed.

E. Addressing a Potential Conflict of Interest:

1. If the Covered Person who may have a Conflict of Interest is a Board or Board Committee member or a member of executive management, the Covered Person shall report the Conflict to the Chief Compliance Officer immediately. The Chief Compliance Officer, in consultation with the CCHHS Office of General Counsel, will review the facts of the situation and make a recommendation to the Chief Executive Officer (or his/her designee), or in the case of a Board member, the Chairman of the Board (or his/her designee), as to whether a potential Conflict exists.

2. The Chief Executive Officer (CEO) (or his/her designee), for those Covered Persons who are subject to his/her supervision, shall decide whether the potential Conflict of Interest that has been disclosed amounts to an actual Conflict of Interest. If it is determined that an actual Conflict of Interest exists then the following procedures shall be taken:
    a. The CEO (or his/her designee), shall direct that the Covered Person refrain from participating in the transaction or decision.
    b. The CEO (or his/her designee), may impose additional safeguards concerning the transaction or decision in order to protect CCHHS' interests. These may include, without limitation, (i) appointing a disinterested person or committee to oversee or review the proposed transaction or arrangement, or (ii) deciding not to pursue the transaction or arrangement.

3. In the case of a Board member, the Chairman of the Board shall allow the Board member to disclose the facts surrounding the potential Conflict of Interest to the Board of Directors in executive session if he/she so desires. Thereafter, the Board member with the potential conflict shall leave the room while the Board of Directors decides whether an actual Conflict of Interest exists. If it is determined that an actual Conflict of Interest exists then the following procedures shall be taken:
    a. The Chairman of the Board shall direct that the Board member refrain from participating in the transaction or decision.
    b. The Chairman of the Board may impose additional safeguards concerning the transaction or decision in order to protect CCHHS' interests. These may include,

without limitation, (i) appointing a disinterested person or committee to oversee or review the proposed transaction or arrangement, or (ii) deciding not to pursue the transaction or arrangement.

4. Failure to comply may result in disciplinary action up to and including termination/severance of relationship (employment, contract, volunteer status).

5. Where necessary, for potential conflicts of interests that involve CountyCare operations, CCHHS Corporate Compliance will disclose in writing any Conflicts of Interest to the Department of Healthcare and Family Services (HFS) no later than seven (7) days after learning of the Conflict of Interest.

    a. In these cases, HFS is responsible for determining whether a Conflict of Interest exists or whether CCHHS failed to make any required disclosure.
    b. HFS will also determine the appropriate remedy for a Conflict of Interest. Available remedies include, but are not limited to, the elimination of the Conflict of Interest or the non-renewal or termination of the MCCN Agreement between CCHHS and the County of Cook for CountyCare operations.

F. Complete and accurate records shall be maintained of all investigations and determinations under this Policy.

POLICY UPDATE SCHEDULE
At least every three (3) years, or more often as appropriate.

REGULATORY REFERENCES
Cook County Ethics Ordinance; Section 2-578 (*Conflicts of Interest*)
Federal Sentencing Guidelines
Federal Anti-Kickback Statute (Stark)
National Institute of Health Guidance
American Medical Association Guidance
PhRMA Code on Interactions with Healthcare Professionals
OIG Self Disclosure Protocol
Physician Payment Sunshine Act
Fraud Enforcement and Recovery Act of 2009
Joint Commission Standard LD.04.02.01

POLICY REFERENCES
CCHHS ~~Standards of Conduct (Code of Ethical Conduct)~~Code of Ethics

POLICY LEAD

Cathy Bodnar, MS, RN, CHC
CCHHS, Chief Compliance and Privacy Officer

REVIEWERS

Audit & Compliance Committee of the Board of Directors
Office of General Counsel
Human Resources

APPROVAL PARTY

John Jay Shannon, MD
CCHHS, Chief Executive Officer
Electronically Approved: April 24, 2013

POLICY HISTORY

Replaces: Oak Forest Hospital COI Policy 2009 Jan

Written:	2011 June 6	
Approved:	2011 Jul 13	Posted: 2011 Aug 25
Updated:	2013 Feb 11 OFH to OFHC	
Reviewed/Revised:	.2013 April 24	Posted: 2013 April 24